Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

REQUEST FOR DDD ELIGIBILITY DETERMINATION

FOR OFFICE USE ONLY

☐ Initial ☐ Reapplication

DDD NUMBER:

Applicant Information

LAST NAME	FIRST NAME	MIDDLE NAME/INITIAL	BIRTHDATE	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE	COUNTY

HOME TELEPHONE NUMBER (including Area Code)	OTHER TELEPHONE NUMBER (including Area Code) ☐ Work ☐ Cell ☐ Message	GENDER ☐ Male ☐ Female

MARITAL STATUS OF APPLICANT

☐ Divorced ☐ Separated
☐ Married ☐ Unmarried Partner
☐ Never Married ☐ Widowed

EDUCATION

☐ 8th Grade or less ☐ Bachelor's Degree
☐ 9 – 11 Grades ☐ Graduate School
☐ High School ☐ No Schooling
☐ Technical or Trade School

Does the applicant have a representative? ☐ Yes ☐ No If yes, name this person:

APPLICANT'S USUAL HOUSING SITUATION

☐ Adult Family Home
☐ Child Foster Home
☐ Group Home
☐ Homeless
☐ Correctional Facility
☐ Licensed Staff Residential
☐ Nursing Facility
☐ Other's Home
☐ Own Home (alone): ☐ Own ☐ Rent ☐ Subsidized
☐ Own Home (spouse/partner
☐ Own Home (with dependent children)
☐ Own Home (with others)
☐ Parent's Home
☐ Relative's Home
☐ State institution, psychiatric
☐ Unknown

Contact Person

NAME	RELATIONSHIP

MAILING ADDRESS	CITY	STATE	ZIP CODE

HOME TELEPHONE NUMBER (including Area Code)	OTHER TELEPHONE NUMBER (including Area Code) ☐ Work ☐ Cell ☐ Message	E-MAIL ADDRESS

MAIL CONTACT ☐ Yes ☐ No	RELATIONSHIP TYPE/ROLE	LEGAL RELATIONSHIP	LIVES WITH APPLICANT ☐ Yes ☐ No

DESCRIBE THE DISABILITY AND THE AGE AT WHICH IT WAS OBSERVED.

SIGNATURE OF ADULT APPLICANT	DATE

SIGNATURE OF REPRESENTATIVE	LEGAL RELATIONSHIP	DATE

SOURCE OF PERSONAL INCOME OF APPLICANT: **CHECK ALL THAT APPLY**

- ☐ Social Security
- ☐ Supplemental Security Income (SSI)
- ☐ General Assistance-Unemployable (GA-U)
- ☐ State supplement
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Veteran's Administration
- ☐ Bureau of Indian Affairs (BIA)
- ☐ Railroad retirement
- ☐ Trust funds
- ☐ Earned income
- ☐ Civil Service
- ☐ None
- ☐ Other (specify below):

Does the Applicant have any kind of Medical Coverage? ☐ Yes ☐ No
If yes, please list.

Medicare? ☐ Yes ☐ No If yes

MEDICARE NUMBER	TYPE

A ETHNIC CODES (CHECK THE CORRECT CODE BELOW)

- ☐ **White**

American or Alaska Native

- ☐ Eskimo
- ☐ Aleut
- ☐ American Indian

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Thai
- ☐ Vietnamese
- ☐ **Black or African American**

Native Hawaiian/ Other Pacific Islander

- ☐ Hawaiian
- ☐ Samoan
- ☐ Guamanian
- ☐ **Other Asian/Pacific Islander**
- ☐ **Other race**
- ☐ **Unreported**

B. Is the applicant Hispanic?

- ☐ No
- ☐ Not Reported
- ☐ Yes (If yes, indicate)
- ☐ Cuban
- ☐ Mexican/Mexican American/Chicano
- ☐ Puerto Rican
- ☐ Other Spanish/Hispanic

PRIMARY LANGUAGE	SPEAKS ENGLISH	UNDERSTANDS ENGLISH	INTERPRETER REQUIRED	TRANSLATIONS REQUIRED
	☐ Yes ☐ No ☐ Limited	☐ Yes ☐ No ☐ Limited	☐ Yes ☐ No	☐ Yes ☐ No

A

PRIMARY SIGNIFICANT OTHER NAME	STREET ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBERS	MAIL CONTACT	RELATIONSHIP TYPE/ROLE	LEGAL RELATIONSHIP TYPE/ROLE	LIVES WITH APPLICANT
	☐ Yes ☐ No			☐ Yes ☐ No

B

SIGNIFICANT OTHER NAME	STREET ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBERS	MAIL CONTACT	RELATIONSHIP TYPE/ROLE	LEGAL RELATIONSHIP TYPE/ROLE	LIVES WITH APPLICANT
	☐ Yes ☐ No			☐ Yes ☐ No

C

SIGNIFICANT OTHER NAME	STREET ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBERS	MAIL CONTACT	RELATIONSHIP TYPE/ROLE	LEGAL RELATIONSHIP TYPE/ROLE	LIVES WITH APPLICANT
	☐ Yes ☐ No			☐ Yes ☐ No

FOR PERSONS UNDER 22 YEARS OF AGE

NAME OF SCHOOL/DAY PROGRAM	START DATE

ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER

SCHOOL DISTRICT NAME

COMMENTS

REQUEST FOR DDD ELIGIBILITY DETERMINATION
INSTRUCTIONS FOR COMPLETION

Applicant Information

The *Applicant* is the person for whom DDD Eligibility is being requested. Please fill in this section completely. If the Applicant does not have a telephone, please put *none*.

Contact Person

A *Contact Person* is someone who will be able to contact the Applicant or give us contact information, if we are unable to reach the Applicant. If there is no legal representative, the name of another person or advocacy entity that can assist if the Applicant is required for Necessary Supplemental Accommodation (NSA) purposes unless the Applicant requests in writing that notice not be sent to anyone else. (WAC 388-825-100)

Legal Representative

Legal Representative means: a parent of a child under eighteen; a person's legal guardian; a person's limited guardian when the limited guardian has authority over health care decisions; a person's attorney at law; a person's attorney in fact (someone with power of attorney who has been authorized to make health care decisions); or any other person who is authorized by law to act for the person in question.

Applicant Usual Housing Situation

Please check the box that best describes the place where the applicant lives.

Describe the disability and the age at which it was observed.

The answers to these questions will help us to understand the type of disability the applicant might have. If you need additional room, please use the back of the paper or another sheet.

Applicant and/or Legal Representative Signature

If the Applicant is under age 18, his or her parent or legal representative must sign and date the application. If the Applicant is age 18 or over, either the Applicant or his or her legal representative must sign and date the application.

Sources of Income of Applicant

Please check all that apply to the Applicant.

Medical Coverage

What type (if any) of medical coverage does the Applicant have? Please write in the type of coverage. If the Applicant has no medical coverage, please write *None*. Please fill in number and type of Medicare coverage if the Applicant has Medicare.

Ethnicity of Applicant and the following section Hispanic

Please check **only one in each section.**

Language

Please write in the Applicant's primary language, including American Sign Language (ASL) or other sign language, Braille, or if the Applicant uses a TDD or other communication device. If the Applicant requires an Interpreter, please check the box to indicate *YES*.

Significant Others

Significant Others are people in the life of the Applicant who are important or might be involved with the well-being of the Applicant. Examples are Biological or Adoptive Parents, Grandparents, Aunts, Uncles, Division of Children & Family Services Social Workers (for children), friends, advocates, and Legal Guardians. If you are uncertain about what to check under legal, you may use **Unknown**. In the case of a Guardianship, we will require copies of the court orders of Guardianship. If an Applicant is adopted, we will require copies of the legal adoption papers.

School/Day Program

Any program which the Applicant attends on a daily basis, such as Early Intervention, school, or other program. If the Applicant does not attend any outside programs on a daily basis, please write *N/A*.

Additional Comments

You may leave this blank, or make any additional brief comments that you think might be of assistance in determining Eligibility.

List of Required Attachments

- ☐ Signed Application with all parts completed.
- ☐ Copies of any medical, or psychological assessments that indicate the Applicant's disability.
- ☐ Signed *Consent to Exchange Confidential Information* – be certain to include addresses and telephone numbers for all providers.
- ☐ Photocopy proof of Applicant's Residency in Washington State (utility bill, voter registration, etc.) If the Applicant is a child, proof of custodial parent's residency.
- ☐ Signed HIPAA form (*Notice of Privacy Practices*).
- ☐ Copy of Social Security card or documentation of SSN, **if one exists**.
- ☐ Copy of Court Ordered Parenting Plan (if applicable).
- ☐ Copy of Guardianship papers (if applicable).
- ☐ Legal Adoption papers. (if applicable).

This application cannot be accepted without all the required attachments. If you have questions, please call your local DDD office.

The toll free numbers are:

Region 1	Spokane	1-800-462-0624	Region 4	Seattle	1-800-314-3296
Region 2	Yakima	1-800-822-7840	Region 5	Tacoma	1-800-248-0949
Region 3	Everett	1-800-788-2053		Bremerton	1-800-735-6740
	Bellingham	1-800-239-8285	Region 6	Tumwater	1-800-339-8227
				Vancouver	1-888-877-3490